COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)
GENERAL CONSENT FOR RELEASE OF INFORMATION

Enrollee or
Provider Name:_____DMAS #: _____

PERMISSION FOR DMAS TO RELEASE INFORMATION:

I hereby give the Department of Medical Assistance Services permission to release to _____ the following information:
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

• _____ Medical • _____ Psychiatric ‰ _____ Financial ‰ _____ Other (Explain)
(INITIAL LINE TO THE RIGHT OF EACH BOX CHECKED)

PERMISSION FOR DMAS TO OBTAIN INFORMATION:

I hereby give the Department of Medical Assistance Services permission to obtain from _____ the following information:
(INDIVIDUAL/ORGANIZATION/PLACE OF BUSINESS)

• _____ Medical • _____ Psychiatric ‰ _____ Financial ‰ _____ Other (Explain)
(INITIAL LINE TO THE RIGHT OF EACH BOX CHECKED)

This consent is good until: _____(Date)
I understand that I can withdraw this consent at any time by contacting DMAS at the address below.

I understand that DMAS will take reasonable steps in accordance with state and federal law to safeguard the confidentiality of my medical and personal records. Medicaid is subject to the confidentiality restrictions set forth in 42 CFR 431.300 through 431.307, Virginia Code § 32.1-325.4, Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Virginia Administrative Code 30-20-90. I also understand that under the Virginia Privacy Act of 1974, I have the right to inspect, correct, or complete this information.

Signed: _____ Date: _____
Enrollee/Provider

Signed: _____ Date: _____
Witness if signed by mark

This form contains patient-identifiable information and is intended for review and use by no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

INSTRUCTIONS: The enrollee or provider granting the release must initial the line to the right of each box checked. Return the original to DMAS after making a copy for your files. Mail the original form to:

Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS-21 (R 04/03)